emailed to Nicole Jobe 12/15/11
Ck#1240

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 10-26-11
Amount 1320/1400

I. IDENTIFICATION

Name: Arbor Place of Clinton

Address: 106 Padgett Drive

City/County/Zip: Clinton, Hickman County, Kentucky 42031

Telephone number: (270) 653-5558

Administrator: Trella Wilson

Date facility operation began at current address: 4/16/2003

Date facility began operation under current owner: 4/16/2003

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled	~~88~~	~~88~~
Nursing Home		
Nursing Facility	88	88
Intermediate Care		
ICF/MR		
Personal Care	10	10

II. CONTROL (check one in each column)

State
County
City
(Private)

(Profit)
Nonprofit

Individual
Partnership
(Corporation)

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Benchmark Healthcare Management
1795 Clarkson Road, Suite 200
Chesterfield, MO 63017

RECEIVED
OCT 26 2011
OFFICE OF INSPECTOR GENERAL

Send Validation letters to:
* Nicole Jobe
NJOBE@BENCHMARKHEALTH.NET

(OVER)

12/31
RB

If facility owned or leased by a corporation, complete the following:

Name of corporation Belmont Gardens, Inc.

Address of corporation 106 Padgett Drive, Clinton, KY 42031

President or Chairman John M. Sells

Vice President

Secretary Arthur Catrino

Treasurer

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
BHH, Inc.	Benchmark Healthcare Management
1795 Clarkson Road, Ste. 200	1795 Clarkson Road, Ste. 200
Chesterfield, MO 63017	Chesterfield, MO 63017

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Signature of authorized representative | President (Title) | 10/22/11 (Date)

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)